NATIONAL QUALITY FORUM
Driving measurable health improvements together

Cardiovascular, Fall 2022 Measure Review Cycle

Measure Evaluation Standing Committee Meeting

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Isaac Sakyi, Manager
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Matilda Epstein, Associate
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February 23, 2023

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Welcome

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Welcome to Today's Meeting!

- Housekeeping reminders:
  - The system will allow you to mute/unmute yourself and turn your video on/off throughout the event
  - Please raise your hand and unmute yourself when called on
  - Please lower your hand and mute yourself following your question/comment
  - Please state your first and last name if you are a Call-In-User
  - We encourage you to keep your video on throughout the event
  - Feel free to use the chat feature to communicate with NQF staff
- If you are experiencing technical issues, please contact the project team via chat on the virtual platform or at cardiovascular@qualityforum.org

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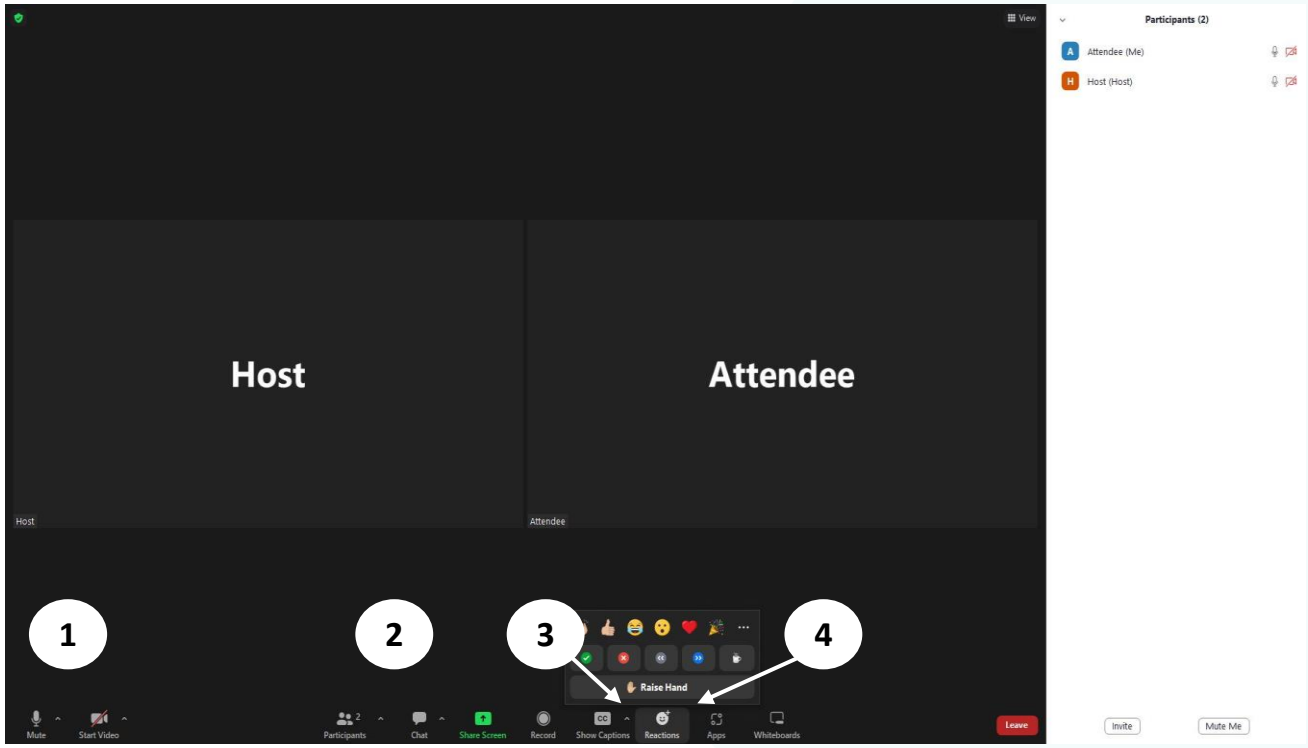
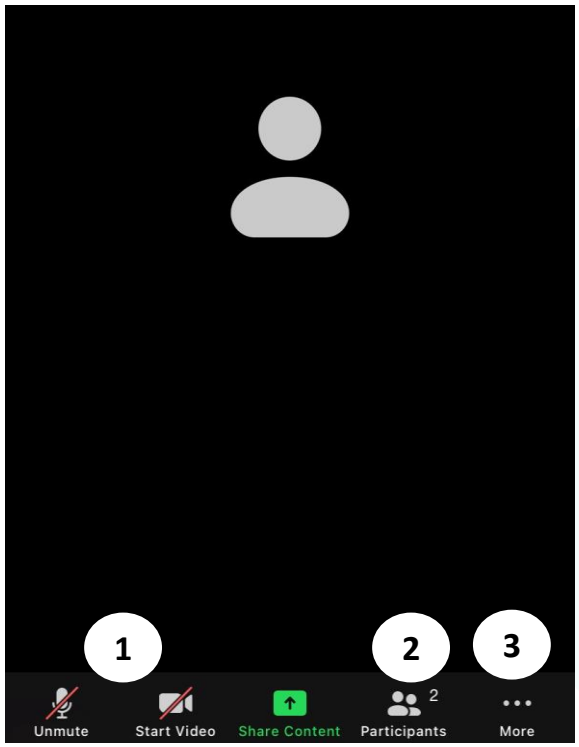
Using the Zoom Platform



1. Click the lower part of your screen to mute/unmute, start or pause video
2. Click on the participant or chat button to access the full participant list or the chat box
3. Click on show captions to enable closed captions
4. To raise your hand, select the raised hand function under the reactions tab

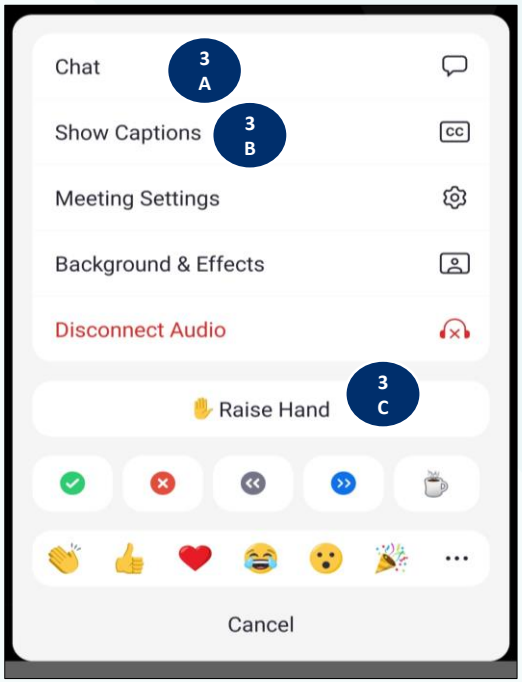
Using the Zoom Platform (Phone View)



1. Click the lower part of your screen to mute/unmute, start or pause video

2. Click on the participant button to view the full participant list

3. Click on “more” button to (3A) view the chat box, (3B) show closed captions, or to (3C) raise your hand. To raise your hand, select the raised hand function under the reactions tab



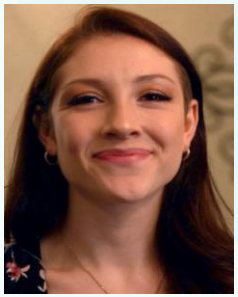
Project Team — Cardiovascular Committee

Udara Perera, DrPHc, MPH
Director

Isaac Sakyi, MSGH
Manager

Hannah Ingber, MPH
Manager

Tristan Wind, BS, ACHE-SA
Analyst



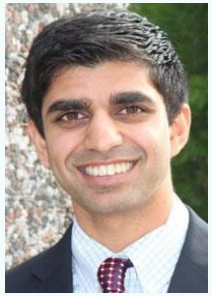
Matilda Epstein, MPH
Associate

Kate Murphy, BS
Associate

Laura Blum Meisnere, MA
Sr. Director

Matthew Pickering, PharmD
Managing Director

Victoria Quinones, AA, PMP
Project Manager



Taroon Amin, PhD
Consultant

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Agenda

- Introductions and Disclosures of Interest
- Overview of Evaluation Process and Voting Process
- Voting Test
- Measures Under Review
- Consideration of Candidate Measures
- Related and Competing Measures
- NQF Member and Public Comment
- Next Steps
- Adjourn

Introductions and Disclosures of Interest

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Cardiovascular Fall 2022 Cycle Standing Committee

- Tim Dewhurst, MD, FACC (Co-Chair)
- Thomas Kottke, MD, MSPH (Co-Chair)
- Michael Alexander, MD, MPH, FACC
- Jacqueline Hawkins Alikhaani
- David Boston, MD, MS
- Linda Briggs, D.N.P., ACNP-BC, FAANP
- Leslie Cho, MD
- Abdulla Damluji, MD, MPH, PhD
- Kumar Dharmarajan, MD, MBA
- William Downey, MD
- Howard Eisen, MD
- Naftali Zvi Frankel, MS
- Jake Galdo, PharmD, MBA, BCPS, BCGP
- Lori Hull-Grommesh, DNP, RN, APRN-BC, ACNP-BC, NEA-BC, FAANP
- Tiffany Johnson
- Charles Mahan, PharmD, RPh, PhC
- Soeren Mattke, MD, DSc
- Ashley Tait-Dinger, MBA
- David Walsworth, MD, FAAFP
- Daniel Waxman, MD, PhD
- Jeffrey Wexler
- Wen-Chih Wu, MD, MPH

Perinatal Standing Committee Members

- Christina Davidson, MD
- Kimberly Gregory, MD, MPH
- Sue Kendig, JD, WHNP-BC, FAANP

Surgery Standing Committee Members

- Vilma Joseph, MD, MPH, FASA
- Alex Sox-Harris, PhD, MS

Overview of Evaluation Process and Voting Process

Roles of the Standing Committee During the Evaluation Meeting

- Act as a proxy for the NQF multistakeholder membership
- Evaluate each measure against each criterion
  - Indicate the extent to which each criterion is met and the rationale for the rating
- Respond to comments submitted during the public commenting period
- Make recommendations regarding endorsement to NQF membership
- Oversee the portfolio of Cardiovascular measures

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Meeting Ground Rules

- Be prepared, having reviewed the measures beforehand
- Respect all voices
- Remain engaged and actively participate
- Base your evaluation and recommendations on the measure evaluation criteria and guidance
- Keep your comments concise and focused
- Be respectful and allow others to contribute
- Share your experiences
- Learn from others

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Process for Measure Discussion and Voting

- Brief introduction by measure developer (3-5 minutes)
- Lead discussants will begin the Standing Committee discussion **for each criterion by:**
  - briefly explaining information on the criterion provided by the developer;
  - providing a brief summary of the pre-meeting evaluation comments;
  - emphasizing areas of concern or differences of opinion; and
  - noting, if needed, the preliminary rating by NQF staff.
    - » This rating is intended to be used as a guide to facilitate the Standing Committee's discussion and evaluation.
- Developers will be available to respond to questions at the discretion of the Standing Committee.
- The full Standing Committee will discuss, then vote on the criterion, if needed, before moving on to the next criterion.

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Endorsement Criteria

- **Importance to Measure and Report (Evidence and Performance Gap)**: Extent to which the measure focus is evidence based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance (**must-pass**).
- **Scientific Acceptability (Reliability and Validity)**: Extent to which the measure produces consistent (reliable) and credible (valid) results about the quality of care when implemented (**must-pass**).
- **Feasibility**: Extent to which the specifications require data that are readily available or could be captured and implemented without undue burden
- **Usability and Use**: Extent to which the measure is being used for both accountability and performance improvement to achieve the goal of high quality, efficient healthcare (use is **must-pass** for maintenance measures).
- **Comparison to related or competing measures:** If a measure meets the above criteria and there are endorsed or new related measures or competing measures, the measures are compared to address harmonization and/or selection of the best measure.

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Voting on Endorsement Criteria

Votes will be taken after the discussion of each criterion

- **Importance to Measure and Report**
  - Vote on Evidence (must pass)
  - Vote on Performance Gap (must pass)
  - Vote on Rationale - Composite measures only (must pass)
- **Scientific Acceptability Of Measure Properties**
  - Vote on Reliability (must pass)
  - Vote on Validity (must pass)
  - Vote on Quality Construct - Composite measures only
- **Feasibility**
- **Usability and Use**
  - Use (must pass for maintenance measures)
  - Usability
- **Overall Suitability for Endorsement**

Voting on Endorsement Criteria (continued)

- **Related and Competing Discussion**
- **Procedural Notes**
  - If a measure fails on one of the must-pass criteria, there will be no further discussion or voting on the subsequent criteria for that measure; the Standing Committee discussion moves to the next measure.
  - If consensus is not reached, the discussion will continue with the next measure criterion, but a vote on overall suitability will not be taken.

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Achieving Consensus

- Quorum: 66% of active Standing Committee members (18 of 27 members).

Vote	Outcome
Greater than 60% yes	Pass/Recommended
40% - 60% yes	Consensus Not Reached (CNR)
<40% yes	Does Not Pass/Not Recommended

- "Yes" votes are the total of high and moderate votes based on the number of active and voting-eligible Standing Committee members who participate in the voting activity.
- Consensus Not Reached (CNR) measures move forward to public and NQF member comment, and the Standing Committee will re-vote during the post-comment web meeting.
- Measures that are not recommended will also move on to public and NQF member comment, but the Standing Committee will not re-vote on the measures during the post-comment meeting unless the Standing Committee decides to reconsider them based on submitted comments or a formal reconsideration request from the developer.

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Committee Quorum and Voting

- Please let staff know if you need to miss part of the meeting.
- We must have quorum to vote. Discussion may occur without quorum unless 50% attendance is not reached.
- If we do not have quorum at any point during the meeting, live voting will stop, and staff will send a survey link to complete voting.
  - Standing Committee member votes must be submitted within 48 hours of receiving the survey link from NQF staff.
- If a Standing Committee member leaves the meeting and quorum is still present, the Standing Committee will continue to vote on the measures. The Standing Committee member who left the meeting will not have the opportunity to vote on measures that were evaluated by the Standing Committee during their absence.

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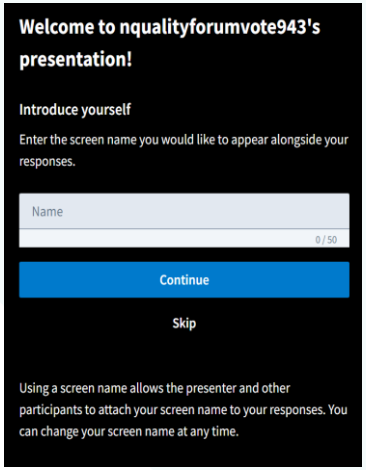
Evaluation Process Questions?

Voting Test

Voting Via Desktop or Laptop Computer (Poll Everywhere)

- Click on the voting link that was emailed to you. You will see a wait message until voting begins.
- When voting opens, you will see the screen below. Enter your first and last name, then click “Continue” to access voting from the options that will appear on the screen.
- Please alert an NQF staff member if you are having difficulty with our electronic voting system.



Measures Under Review

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Fall 2022 Cycle Measures

- **Two Maintenance Measures for Standing Committee Review**
  - **#2377** Overall Defect Free Care for Acute Myocardial Infarction (AMI) (American College of Cardiology (ACC))
  - **#2558** Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery (Centers for Medicare & Medicaid Services (CMS)/Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (Yale CORE))
- **Two New Measures for Standing Committee Review**
  - **#3716** Cardiovascular disease (CVD) Risk Assessment Measure – Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized tool (University of California, Irvine)
  - **#3735** CVD Risk Follow-up Measure – Proportion of patients with a positive CVD risk assessment who receive follow-up care (University of California, Irvine)

NQF Scientific Methods Panel (SMP)

- The Scientific Methods Panel (SMP), consisting of individuals with methodologic expertise, was established to help ensure a higher-level evaluation of the scientific acceptability of complex measures.
- The SMP's comments and concerns are provided to developers to further clarify and update their measure submission form with the intent of strengthening their measures to be evaluated by the Standing Committee.
- Certain measures that do not pass on reliability and/or validity are eligible to be pulled by a Standing Committee member for discussion and a revote.

NQF Scientific Methods Panel Review

- The SMP independently evaluated the scientific acceptability of one measure:
  - **#2377** Overall Defect Free Care for AMI (American College of Cardiology)
- The SMP passed this measure.

Consideration of Candidate Measures

#2377 Overall Defect Free Care for AMI

- **Measure Steward/Developer:** ACC
  - Maintenance measure
- **Brief Description of Measure:**
  - The proportion of acute MI patients >= 18 years of age that receive "perfect care"; based upon their eligibility for each performance measures

#2558 Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery

- **Measure Steward/Developer:** CMS/Yale CORE
  - Maintenance measure
- **Brief Description of Measure:**
  - The measure estimates a hospital-level all-cause, risk-standardized mortality rate (RSMR) for patients 65 years and older discharged from the hospital following a qualifying isolated CABG procedure. Mortality is defined as death from any cause within 30 days of the procedure date of an index CABG admission. CMS annually reports the measure for patients who are 65 years or older and enrolled in fee-for-service (FFS) Medicare and hospitalized in non-federal hospitals.

Lunch: 30 Minutes

#3716 CVD Risk Assessment Measure – Proportion of pregnant/postpartum patients that receive CVD Risk Assessment with a standardized tool

- **Measure Steward/Developer:** University of California, Irvine
  - New measure
- **Brief Description of Measure:**
  - This measure determines the percentage of pregnant or postpartum patients at a clinic who were assessed for CVD risk with a standardized tool, such as the CVD risk assessment algorithm developed by the California Maternal Quality Care Collaborative (CMQCC). The aim is to perform a CVD risk assessment using a standardized tool on all (100 %) eligible pregnant/postpartum patients. Every single patient should be assessed for CVD risk at least once during their pregnancy and, if needed, additional times when new symptoms present during the pregnancy and/or postpartum period. A threshold has still to be determined ("at least xxx % of patients who received risk assessment"). The measure can be calculated on a quarterly or annual basis.

#3735 CVD Risk Follow-up Measure – Proportion of patients with a positive CVD risk assessment who receive follow-up care

- **Measure Steward/Developer:** University of California, Irvine
  - New measure
- **Brief Description of Measure:**
  - This measure assesses the rate of pregnant and postpartum patients who are determined to be at risk for CVD using a standardized risk assessment who received appropriate follow-up in the form of cardiology consultations and tests. The unit of measurement is the individual patient, and the population is comprised of patients who have an outpatient or inpatient prenatal or postpartum visit at a clinic or facility. This includes pregnant and postpartum emancipated minors. The measure can be calculated at the hospital system level or clinic site level. The measure can be calculated annually.

Break: 15 Minutes

Related and Competing Discussion

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Related and Competing Measures

- If a measure meets the four criteria ***and*** there are endorsed/new related measures (same measure focus ***or*** same target population) or competing measures (both the same measure focus ***and*** same target population), the measures are compared to address harmonization and/or selection of the best measure.

*	Same concepts for measure focus-target process, condition, event, outcome	Different concepts for measure focus-target process, condition, event, outcome
Same target population	**Competing measures - Select best measure** from competing measures or justify endorsement of additional measure(s).	**Related measures - Harmonize** on target patient population or justify differences.
Different target patient population	**Related measures - Combine** into one measure with expanded target patient population or justify why different harmonized measures are needed.	Neither a harmonization nor competing measure issue

*Cell intentionally left blank

The National Quality Forum. Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement. September 2021; 34.

Related and Competing Measures (continued)

- Related and competing measures will be grouped and discussed after the recommendations for all related and competing measures are determined. Only measures recommended for endorsement will be discussed.
- The Standing Committee can discuss harmonization and make recommendations. The developers of each related and competing measure will be encouraged to attend any discussion.

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#2377 Overall Defect Free Care for AMI: Related Measure

- #3613e Appropriate Treatment for ST-Segment Elevation for Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)

#2377 Overall Defect Free Care for AMI: Related Measure

- **#3613e** Appropriate Treatment for ST-Segment Elevation for Myocardial Infarction (STEMI) Patients in the Emergency Department (ED)
  - Steward/Developer: CMS/Yale CORE
  - Description: The percentage of ED patients with a diagnosis of STEMI who received appropriate and timely treatment. The measure will be calculated using electronic health record (EHR) data and is intended for use at the facility level in a CMS accountability program, through which it may be publicly reported.
  - Numerator: ED STEMI patients aged 18 and older whose time from ED arrival to fibrinolysis is 30 minutes or fewer OR Non-transfer ED STEMI patients who received PCI at a PCI-capable hospital within 90 minutes of arrival OR ED STEMI patients who were transferred from a non-PCI capable hospital within 45 minutes of ED arrival at a non-PCI capable hospital.
  - Denominator: ED patients 18 years of age and older with STEMI who should have received appropriate and timely treatment for STEMI.
  - Target Population: N/A
  - Care Setting: Outpatient Services
  - Level of Analysis: Facility

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#2377 Overall Defect Free Care for AMI: Related Measure Discussion

- Are the measure specifications for the related measure harmonized to the extent possible?
- Are there differences that could impact interpretability and add data collection burden?
- Are the differences justified?

#2377 Overall Defect Free Care for AMI: Competing Measure

- #0137 ACEI or ARB for left ventricular systolic dysfunction - Acute Myocardial Infarction (AMI) Patients

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#2377 Overall Defect Free Care for AMI: Competing Measure (continued)

- **#0137** ACEI or ARB for left ventricular systolic dysfunction-Acute Myocardial Infarction (AMI) Patients
  - Steward/Developer: CMS
  - Description: Percentage of acute myocardial infarction (AMI) patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.
  - Numerator: AMI patients who are prescribed an ACEI or ARB at hospital discharge
  - Denominator: AMI patients with chart documentation of a left ventricular ejection fraction (LVEF) < 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction
  - Target Population: Elderly
  - Care Setting: Inpatient/Hospital
  - Level of Analysis: Facility; Population: Regional and State

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#2377 Overall Defect Free Care for AMI: Competing Measure Discussion

- Do you agree that the measures have both the same measure focus and target population?
- Should both measures be endorsed? Are two or more measures justified?
- Is one measure superior to the other (e.g., a more valid or efficient way to measure quality)?

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#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measures

- #0696 STS CABG Composite Score
- #1502 Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair + CABG Surgery
- #2515 Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery

#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measure

- **#0696** STS CABG Composite Score
  - Steward/Developer: The Society of Thoracic Surgeons
  - Description: The STS CABG Composite Score comprises four domains consisting of 11 individually NQF-endorsed cardiac surgery measures:
    Domain 1) Absence of Operative Mortality – Proportion of patients (risk-adjusted) who do not experience operative mortality. Operative mortality is defined as death during the same hospitalization as surgery or after discharge but within 30 days of the procedure;
    Domain 2) Absence of Major Morbidity – Proportion of patients (risk-adjusted) who do not experience any major morbidity. Major morbidity is defined as having at least one of the following adverse outcomes: 1. reoperations for any cardiac reason, 2. renal failure, 3. deep sternal wound infection, 4. prolonged ventilation/intubation, 5. cerebrovascular accident/permanent stroke;
    Domain 3) Use of Internal Mammary Artery (IMA) – Proportion of first-time CABG patients who receive at least one IMA graft;
    Domain 4) Use of All Evidence-based Perioperative Medications – Proportion of patients who receive all required perioperative medications for which they are eligible. The required perioperative medications are: 1. preoperative beta blockade therapy, 2. discharge anti-platelet medication, 3. discharge beta blockade therapy, and 4. discharge anti-lipid medication.

    All measures are based on audited clinical data collected in a prospective registry. Participants receive a score for each of the domains, plus an overall composite score. The overall composite score is created by "rolling up" the domain scores into a single number. In addition to receiving a numeric score, participants are assigned to rating categories designated by one star (below average performance), two stars (average performance), or three stars (above average performance). For consenting participants, scores and star ratings are publicly reported on the STS website.

#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measure (continued)

- **#0696** STS CABG Composite Score (continued)
  - Numerator: N/A
  - Denominator: N/A
  - Target Population: Elderly
  - Care Setting: Inpatient/Hospital
  - Level of Analysis: Clinician: Group/Practice; Facility

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#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measure

- **#1502** Risk-Adjusted Operative Mortality for Mitral Valve (MV) Repair + CABG Surgery
  - Steward/Developer: The Society of Thoracic Surgeons
  - Description: Percent of patients aged 18 years and older undergoing combined MV Repair and CABG who die, including both 1) all deaths occurring during the hospitalization in which the procedure was performed, even if after 30 days, and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure
  - Numerator: Number of patients aged 18 years and older undergoing combined MV Repair and CABG who die, including both 1) all deaths occurring during the hospitalization in which the operation was performed, even if after 30 days, and 2) those deaths occurring after discharge from the hospital, but within 30 days of the procedure
  - Denominator: All patients undergoing combined MV Repair + CABG
  - Target Population: Elderly
  - Care Setting: Inpatient/Hospital
  - Level of Analysis: Clinician: Group/Practice; Facility

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#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measure (continued)

- **#2515** Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery
  - Steward/Developer: Centers for Medicare & Medicaid Services/Yale New Haven Health Services Corporation - CORE
  - Description: The measure estimates a hospital-level risk-standardized readmission rate (RSRR), defined as unplanned readmission for any cause within 30-days from the date of discharge for a qualifying index CABG procedure, in patients 65 years and older. An index admission is the hospitalization for a qualifying isolated CABG procedure considered for the readmission outcome.

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#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measure (continued)

- **#2515** Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery (continued)
  - Numerator: The outcome for this measure is 30-day readmissions. We define readmission as an inpatient acute care admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from the index admission for an isolated CABG surgery in patients 65 and older. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only the first one is counted as a readmission. The measure looks for a dichotomous yes or no outcome of whether each admitted patient has an unplanned readmission within 30 days. However, if the first readmission after discharge is considered planned, any subsequent unplanned readmission is not counted as an outcome for that index admission because the unplanned readmission could be related to care provided during the intervening planned readmission rather than during the index admission.
  - Denominator: The cohort includes admissions for patients who are age 65 and older with a qualifying isolated CABG procedure and complete claims history for the 12 months prior to the index admission.
  - Target Population: Populations at Risk; Elderly
  - Care Setting: Inpatient/Hospital
  - Level of Analysis: Facility

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#2558 Hospital 30-day, all-cause risk-standardized mortality rate (RSMR) following coronary artery bypass graft (CABG) surgery: Related Measures Discussion (continued)

- Are the measure specifications for the related measure harmonized to the extent possible?
- Are there differences that could impact interpretability and add data collection burden?
- Are the differences justified?

NQF Member and Public Comment

Next Steps

Measure Evaluation Process
After the Measure Evaluation Meeting

- Staff will prepare a draft report detailing the Standing Committee's discussion and recommendations
  - This report will be released for a 30-day public and member comment period
- Staff compiles all comments received into a comment brief, which is shared with the developers and Standing Committee members
- Post-comment call: The Standing Committee will reconvene for a post-comment call to discuss the comments submitted
- Staff will incorporate comments and responses to comments into the draft report in preparation for the Consensus Standards Approval Committee (CSAC) meeting
- The CSAC meets to endorse measures
- Opportunity for public to appeal endorsement decision

Activities and Timeline – Fall 2022 Cycle

***All times ET**

Meeting	Date, Time*
Measure Evaluation Web Meeting #2	February 27, 2023; 12PM-3PM
Draft Report Comment Period	TBD
Standing Committee Post-Comment Web Meeting	TBD
CSAC Review	TBD
Appeals Period (30 days)	TBD

Spring 2023 Cycle Updates

- Intent to submit deadline was January 5, 2023
- 14 measures have been submitted.

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Project Contact Info

- Email: cardiovascular@qualityforum.org
- NQF phone: 202-783-1300
- Project page: https://www.qualityforum.org/Cardiovascular.aspx
- SharePoint site: https://share.qualityforum.org/portfolio/Cardiovascular/SitePages/Home.aspx

Questions?

THANK YOU.

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https://www.qualityforum.org